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Parenting programmes: an important ECD intervention strategy

Judith L. Evans
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PARENTING PROGRAMMES

AN IMPORTANT ECD INTERVENTION STRATEGY

Judith L. Evans

Executive Summary

‘The earliest years represent the period of the most dramatic development in the individual’s life. At the same time...these are the years of greatest vulnerability. If the young child is surrounded by supportive and positive influences it is likely that she will survive and thrive. These outcomes, surviving and thriving, are, to a very large extent dependent upon how well-equipped families, especially primary caregivers, are to care for, respond to and manage the needs of young children from birth onwards.’

(Grover, 2005, 1)

Grover’s statement sums up the essence of this article, which provides a summary of current literature on the nature of parenting programmes for young children and their impact, post-intervention and over time. The article suggests the following:

1. The most rapid period of a child’s growth is during the early years, setting the foundation for all later well-being.
2. All children need protection and care during those early years to support all aspects of their growth and development – physical, social, emotional, cognitive and spiritual
3. The best people to provide that support are the child’s parents. While it is recognized that not all children are raised by their parents, nonetheless, all children require quality parenting.
4. High quality early intervention programmes that provide parents with information and support in their parenting role, and in their own development, can make a

significant difference in a child's life course. Regardless of the strategy used in working with parents, it is important to remember that parents are not "instruments" for getting to children; parents need to be valued as people in their own right. This means working with parents in relation to their various needs, not just focusing on child development information and parenting.

5. Programmes that work best provide regularity and intensity of inputs through one-to-one home visits and/or parenting groups over at least a year; two to three years of intervention are more likely to sustain gains over time. Parenting programmes are most efficacious for at-risk families.
6. Inputs in parenting programmes are not directly correlated with child outcomes. Programmes that provide parents with knowledge and skills that lead to interactions with their children that support the child's overall development have the potential to be evidenced in all aspects of the child's life – depending on individual child characteristics and the nature of the context within which the child lives. Thus there is no single formula for creating the ideal parenting programme.
7. Outcomes of parenting programmes may not be evident on the same variables over time. At one stage outcomes may be evident in school retention and achievement and social behaviour. At another point in time there may be economic and societal outcomes. Thus it is important to be open to alternative ways of assessing impact, both post-programme and over the long-term.

I Background

A. The Importance of the Early Years

Over the past 20 years knowledge about children's development prenatally and during the first three years of life has accumulated rapidly – drawn from (but not limited to) the fields of biology, brain research and its associated fields (neurobiology, neurology, psychology, health and nutrition). In their landmark book, *The Secret Life of the Unborn Child*, Verny & Kelly (1981) were some of the first to bring to light preliminary research that suggested that infants in the womb are influenced by their parents – mothers and fathers – and that the context of nurturing (or lack thereof) has a lasting impact on the infant and young child's development. When the book was published other scientists were highly sceptical that once the gene structure was determined (nature), the trajectory of the child's development could be influenced in the womb and beyond (nurture). Yet as research accumulates it is becoming increasingly evident that early experiences are the building blocks for all later development, and that parents have a critical role to play in the unfolding of the child's biology. As Lipton (2005) notes, 'experimental psychologists and neuroscientists are demolishing the myth that infants cannot remember – or for that matter learn – and along with it the notion that parents are simply spectators in the unfolding of their children's lives'(page 156). Parents do matter; parenting is important for individual children and for society as a whole.

B. A focus on families

The most important factor in a child's healthy development is to have at least one strong relationship (attachment) with a caring adult who values the well-being of the child. Lack of a consistent caregiver can create additional risks for children.

Engle, Lhotska and Armstrong 1997

One of the keys to supporting the child's optimal development is to provide appropriate care during the early years. Care is much more than keeping the child safe and free from harm. Care is an interactive process. It is the parent/caregiver in interaction with the child that determines the quality of care received and the ways in which the child develops (Engle & Lhotska, 1997). As noted by Grover (2005), 'If given appropriate care, children make remarkable gains in physical and motor development, in linguistic and cognitive functioning as well as dramatic progress in their emotional, social, regulatory and moral capacities'. That is why it is so important that children have appropriate supports in terms of the following: protection (an environment that is safe from physical and emotional harm); good health (safe water, hygiene); appropriate nutrition (including exclusive breastfeeding for the first six months), stimulation (opportunities to explore the world, express curiosity, engage in problem solving); language development (listening and responding); and most of all in terms of interaction with and attachment to caring adults.

While the importance of parenting is a topic in current scientific and psychological research, there is also an international imperative embedded in the Convention on the Rights of the Child (CRC)) that defines the rights of children, within which it is stated that the family is responsible for guaranteeing the child's rights. However, families are not to be held responsible to undertake the guaranteeing of children's rights on their own; they must be supported by the State (Article 18.2) and 'parents' is inclusive of mother and father (Article 18.1).

Programming experience reinforces the importance of working with parents and families in order to maximize child outcomes. In the late 1990s, the World Health Organization (WHO) commissioned a review of programmes seen as effective in improving the health, nutrition, and psychological development of children in disadvantaged circumstances. The review (*A Critical Link*, 1999) led to the conclusions that the most effective programmes:

- Focus on the children who are in the “critical window” of life—improvements before birth and during the first 2 to 3 years of life have the greatest impact on the child’s future growth and development
- Focus on children who are most at risk—the greatest improvements were seen in children who were impoverished and undernourished
- Combine several interventions, for example: to promote good nutrition, improve mother-child interactions, stimulate psychosocial development, and improve the child’s health
- Involve parents and other caregivers in improving the child’s care.

The conclusions are evident, families are critical to the well-being of children. Ironically, the family institution, which is seen as a place of refuge, has been the institution most affected by the various changes taking place in the contemporary world.

C. Parenting today

From a global perspective the great majority of families are in crisis; they are struggling with the political, social and economic conditions that undermine their ability to provide appropriate supports to young children. Whereas in the past most societies could claim a normalised parenting pattern – either an extended family model, a community/ tribal model, a nuclear family or some other stable pattern – now most societies are reporting that their family norms are disrupted, and the effects on children and parents alike are devastating. The on-the-job training many parents used to receive from extended family members or from religious and cultural traditions are largely unavailable to contemporary parents. In addition, the lack of cohesion within the community is an even greater problem. It is not always clear who is providing parenting. Thus we need to be concerned with the kind of parenting that young children receive, regardless of who, willingly or unwittingly, has a parenting role.

It is generally taken for granted that the primary caregivers are a child's biological parents, but this assumption is not always valid. For an ever-increasing number of the world's children, biological parents are not available to them much of the time, if at all. Parents are leaving children behind to go in search of work; they are losing children in the context of Diaspora and armed conflicts; they are leaving children in the care of other children while trying to earn a living; they are dying of AIDS; they are being ravaged by drugs and poverty; they are trying to carry on while juggling inhuman demands caused by long work days and the need to simply survive.

When a family is under economic or social stress, children are likely to receive less adequate care. When there are multiple demands on adults in the household (work in and outside the home, other children, single parenting, lack of food security, and so forth), it is more difficult for the caregiver to provide appropriate care. Helping caregivers develop the ability to respond to children's cues may require ensuring that parents also have appropriate supports. So, while the ultimate goal of parenting programmes is to enhance children's well being, this cannot be done without taking into consideration the needs of parents and the family, within the context of the society as a whole.

II Creating Parenting Programmes

It is obvious that parents did not wait for us to learn how to love, rear and educate their children, and the idea to educate them can seem paradoxical or abusive. What do we believe we can give them that they do not already have? What, are we sure we know better than they do?

(Pressoir, 2004)

The broad objective within parenting programmes is to create awareness of the importance of the caregivers' role in relation to supporting children's growth and development, and to strengthen or modify caregivers' attitudes, beliefs and practices in relation to caring for a child. While all children need the care described above, the way in which the needs are manifested and the way they are provided for will differ from culture to culture. However, ultimately parent programmes should empower caregivers in ways that will improve their care of and interaction with young children and enrich the immediate environment within which children live.

The term *parenting programme* is being used to cover both *parent education* and *parent support* programmes. Even though the terms are often used indiscriminately, is important to understand the difference between them. *Parent education* is any training or learning activity provided for parents. Parenting is only one category of content that can be taught in a parent education course. Other content might be related to literacy, skill development, management, etc. that is being provided to increase parental skills to increase family income and well-being. On the other hand, *parent support* provides those engaged in parenting with information on how to give children the kinds of parenting they require to maximize their potential (Evans, 1999).

A. Content development and delivery

It is important to operate from the assumption that those engaged in parenting are doing the best possible job that they can, given the context and their own experiences. This needs to be respected and acknowledged before people are open to alternatives.

Content for parenting programmes is based on the latest scientific information available, and it is important to realize that this changes all the time. Linked to how the content is created is how it is delivered. The ways in which parenting programmes are developed and the process for delivering them often reveal the attitudes (and sometimes prejudices) of programmes developers about parental knowledge and skills and what motivates people to change their attitudes and behaviours.

Content for parenting programmes is most often chosen based on the assumption that parents lack knowledge about child care and need to be enlightened. This leads to a delivery method where parents listen while a specialist instructs. There is little or no dialogue and exchange among parents. According to Hyde and Kabiru (2003), in Sub-Saharan Africa parents are likely to be passive recipients of information from outsiders, and due to their colonial history are willing to take on information provided by outsiders. Hyde and Kabiru suggest that colonialization has left the population with expectations of what will be provided by people from outside the community/culture. One consequence of this is that information provided through parenting programmes will be seen as ‘truth’ and not questioned – although what is being proposed may not, in fact, be appropriate nor result in positive changes in attitudes, beliefs or practices.

Some parenting programmes have been created through processes that are more likely to result in behaviour change. One strategy is to contextualize content. While still relying on models from outside the culture, local adaptations are made. This may include content additions to reflect the culture and/or taking examples from the setting. For example the HIPPY model was developed in Israel in 1981, and has been adapted over time in Ireland, Turkey, The Netherlands, and the USA. In all instances it was nationals from the

country who made the adaptations, and therefore it is assumed that as ‘insiders’ they can make an accurate assessment of how to make the content developed by ‘outsiders’ appropriate to the context.

Another approach is to create an interactive process in developing curriculum and the delivery of the service that shifts some of the power and control from the programme developer to the local population. This approach uses an interactive process for working with a community to identify, acknowledge and use parental strengths as the basis for programming. However, it is not easy to create such programmes. The dilemma that project designers face is how to support existing knowledge, while also introducing new practices and beliefs that have been shown to be effective in terms of child development. The dilemma involves the ability to:

- recognize, respect and build on existing strengths within the traditional, while acknowledging and responding to the need for access to new information
- build confidence in relation to local positive practices, while building trust that what is being offered from outside is of value
- share experiences and generate solutions, while introducing ideas that may contradict current practices, beliefs and realities

One of the ways that programmes have addressed these dilemmas is by creating a parenting programme that is based on what parents do on a day-to-day basis with their children. Two examples illustrate this process. One was developed in Thailand by a Thai Doctor working in the Ministry of Health, and the other is a home visiting programme in Sri Lanka developed by a Sri Lankan national.

The Integrated Nutrition and Community Development Project in Thailand was developed in 1979 out of a concern that infants and young children suffered from Protein Energy Malnutrition (PEM), and it was thought that if local practices were better understood it would be possible to determine where interventions could be made to improve nutritional and developmental outcomes that would be acceptable and practical.

As a basis for the project, childrearing attitudes and practices were studied to know what mothers were currently doing and to determine how that might affect children's nutritional status. Through the studies a number of nutritional and social taboos were discovered that were not beneficial to the child. For instance, there was a belief that colostrum was bad for the infant and that newborns were incapable of sucking. This meant that breastfeeding was not begun immediately following birth. It was delayed, with the consequence that many mothers found it difficult to breastfeed and quickly turned to bottle feeding. This resulted in children not receiving the nutrition which breastfeeding provides.

Another important belief that needed to be addressed was that few mothers knew that infants are capable of seeing and hearing at birth. As a result, mothers did not interact with their infants, who were left for hours in hammocks that essentially blocked them from seeing anything in their environment. Related to this was the mother's lack of awareness of her own capacity to make a difference in the child's development. Mothers had little understanding of how they could make use of existing resources to create a more nurturing environment for the child and how important it was for them to interact with the child.

With these practices in mind, a series of interactive videos was created. One was specifically oriented toward child development, aimed at creating the mother's awareness of her child as an individual with early perceptual ability, and of the importance of play and of mother-child interaction in that play and in supplementary feeding. A second video compared two fifteen-month-old boys, one malnourished, the other normal. The video identified differences in the mother's behaviour (her feeding and caring practices) in each scenario, as well as differences in the kinds and amounts of food provided to the child. Health communicators in each village, who served as distributors of supplementary food, were trained in the use of the videos, which were presented as often as needed in each village.

Another example of creating a curriculum based on observation of day-to-day life comes from Sri Lanka, where a research study undertaken in the country in the late 1980s let programme planners know that there was a lack of awareness among parents, particularly those in rural areas, of the importance of their role in supporting the child's development. A further discovery from the survey was that the families in the region were extremely isolated and had no access to basic services. So a home visiting programme was chosen as an appropriate vehicle to reach these parents.

As described in Evans (et al. 2000), the objective of the home visits was to illustrate to parents (fathers and mothers) the ways in which their daily interactions with the child supported the child's development. The approach made optimal use of the home and the immediate environment as the primary source of learning and development. To develop the curriculum, visits were made to homes and observations made of the kinds of activities that adults and children were engaged in throughout the day. The researchers got parents to talk about their children, what they were like and what they could do. This stimulated parents to pay more attention to what their children were doing and got them involved in what their children could learn. The resulting curriculum is based entirely on household activities and on the use of real objects in real situations. In essence, the curriculum reinforces the value of what people are already doing with their children. Parents could see how what they do on a daily basis helps children to acquire skills and knowledge. The materials and process of working with parents reinforced and elaborated on the importance of the positive activities, with some modifications suggested to shift less favourable interactions.

B. Components of Parenting Programmes

In order to be effective, whatever the approach, parenting programmes need to be of high quality. One of the important ingredients in a quality programme is the planning that takes place in creating the programme. The planning process involves making choices about: who will receive the programme; the age of the child at the time the intervention

begins; the caregiver who will be the focus of the intervention; the strategy that will be used for reaching and working with caregivers; the knowledge, skills and personal qualities of those who provide the service; the kinds of training and support they will receive; and the kinds of documentation that will be required to monitor and evaluate the programme over time. Choices within each of these dimensions have to be made in relation to the context where the programme will be offered and the resources available – financial and human. In the following section of the paper some of the elements within each of these dimensions will be noted but not discussed extensively, since each of them warrants a paper on its own.

1. The recipients

Will the programme be open to everyone in the geographic region/country, or will it be delivered to a select population? Some programs are designed to be available universally based on the belief that all parents can benefit from parenting education. Others have been targeted at specific at-risk populations, for example, families with premature or low-birth weight babies, teen-age mothers, isolated families, or families who are considered at risk for economic and/or social reasons. Both approaches have their pros and cons, and costs will certainly be a key factor in the equation. Grantham-McGregor et al., (N.D.) suggest:

‘When resources are limited, the highest-risk individuals in a population should be targeted for intervention. However, it is important to realize that the highest-risk individuals in a population may occur relatively infrequently. Focusing solely on these individuals may not have a large impact on the community. Further, some communities may have such a high prevalence of multiple risk factors (e.g., orphaned children, famine, widespread maternal illiteracy) that the whole population should be targeted’.

In other words, there are no strict guidelines on how to select a population focus for a programme based on experience and/or research. It depends on the goals of the

programme, the level of risk within the population as a whole, the resources available, and the degree to which the population has access to services. If the goal is to reach at-risk populations then a more targeted approach is appropriate. However, if the goal is to raise the standard of parenting within a community/society, then the answer is to provide a more universal programme.

a. Age of infant/child

Another dimension of ‘who’ is the age of the child when work is begun with families. While some programmes begin prenatally (typically those that are connected to a comprehensive health service), others start working with parents after the birth of the child. These programmes can continue until the child is 2-3 years of age, at which time the child may transition into a pre-school programme with the parenting programme continuing in one form or another until the child enters school. As can be seen in the evaluation section that follows, each of these choices has implications for child and maternal outcomes.

b. The caregiver focus of parenting programmes

As noted earlier, the assumption cannot be made that the biological parents (especially the mother) will always be the one to work with in a parenting programme. Increasingly people have recognized the importance of working with fathers and exploring the ways to do so. An important strategy is to look at how fathers are involved traditionally to figure out what roles fathers currently play in the culture.

In a study of fathering in South Africa it was estimated that 50%+ of fathers do not have daily contact with their children (Richter, 2005) The study goes on to explore the reasons why men are absent in terms of parenting and makes recommendations regarding policies and practices that could be changed that would support men’s greater participation in their children’s lives. (For more on the study see www.hsrc.ac.za/fatherhood.)

The traditional role of fathers in Nigeria was the focus of a study by Hua (2004) who concluded that if fathers are going to increase their participation in child rearing, the society as a whole needs to change its attitude and expectations toward father involvement.

The role of fathers in early childhood programmes has been the topic of several recent publications. In 2001, *Early Childhood Matters* (#97) focused on the inclusion of fathers in early childhood programmes. (The issue can be downloaded from www.bernardvanleer.org.) *Men in the Lives of Children*, Coordinators' Notebook #16, 1995, from the Consultative Group on Early Childhood Care and Development (www.ecdgroup.com) addressed the role of men in the wider society in supporting children's development.

Current exploration of the role of fathers in families and childrearing is being conducted through the Early Head Start Research and Evaluation Project in the USA. The research focuses on the role low-income fathers play in the lives of their infants and toddlers, in their families, and in the Early Head Start programs in which they participate. (Reports from the father studies include practitioner study findings, can be viewed at http://ccfl.unl.edu/projects/cprojects/ecp/ehs_study.html, a special issue of the journal *Fathering: A Journal of Theory, Research, and Practice About Men as Fathers*, edited by Natasha Cabrera (Winter 2004, 2-1), is devoted to findings from the Early Head Start study and can be viewed at http://www.mensstudies.com/tocfat2_1.html).

In addition to fathers, members of the extended family are important. Both mothers and mothers-in-law tend to play a key role in relation to child rearing in most cultures, sometimes creating conflict should the mother begin to take on new ideas. (Molloy, 2002) notes:

There is a bond between mother and daughter in working-class communities where there is a tradition of a daughter drawing on her mother's knowledge, particularly if she lives near her mother. The daughter has a lot to gain from this

relationship and often nurtures it. But ideas on childcare can change, which can cause the grandmother's skills to become obsolete. The daughter may want to update their information and so is willing to accept guidance and support from outsiders, which may cause some tension between the Community Mother and the grandmother, who might see the Community Mother's visit as a threat.'

2. Content

Ultimately the goal of all parenting programmes is to have a positive impact on child outcomes. The process for getting there varies across programmes. For example, some of the programmes in the health field focus narrowly on immediate growth outcomes for the child. The programmes are quite intentional in their focus and very specific short-term outcomes are sought. The impact of these programmes can be seen at the end of the intervention, and because of related research, the long-term outcomes for children can be extrapolated (e.g., low birth-weight babies are more at-risk developmentally; programmes that focus on healthier birth outcomes (increasing the weight of the newborn) are likely to change the life course of an infant).

Another approach is to give primary attention to the needs and interests of the mother, with the belief that if her life is going well she will then have the energy to focus on the child's needs. While the explicit focus of the programme is said to be on facilitating the mother/child interaction, implicitly the focus is on the mother first. This is the approach taken by The Community Mothers Programme in Ireland (Molloy, 2002), and the Mothers Inform Mothers initiative in The Netherlands (de Graaf et al., 2000), where home visitors from the community work on a one-to-one basis with other mothers to support their overall 'empowerment'. These programmes focus on enhancing mother's confidence and self-esteem in all aspects of her life.

3. Reaching parents/caregivers

There are three basic approaches in working with parents: through one-on-one exchanges; through some form of parent group designed to facilitate the provision and sharing of information; and through the media. Some programmes choose to use two or all of these approaches. The choice of home visiting and/or parent groups will often be based on the age group to be reached (generally programmes for children from birth to age 3 at least begin with home visits, although parent groups can be added along the way). When children are in the 3 to 5 age range then parent groups are more common, and are being provided alongside a centre-based programme for the children.

Within the safety of home visits and parenting groups, caregivers can raise a full range of issues and get support related to their child's and their own development. The use of media is more impersonal and does not allow for an interactive process. Nonetheless media are an important tool for raising awareness of early childhood rights and issues nationally and internationally.

a. Face to face – home visits and parenting groups

Home visits provide a one-to-one parent education and support experience and have been used as a way to serve hard-to-reach families, frequently in situations where parents are isolated and/or they are unlikely to participate in a parent group. The most common model is for the home visit to focus on the child's development and on the ways the parents can promote that development.

In terms of working with parents in groups, many programmes focus primarily on the ways in which parents (generally the mother) can support the child's development, while in some programmes parenting groups also provide support to the woman herself. Parenting groups can be developed to stand on their own, or they may be offered in conjunction with a centre-based or home-based programme. They may also be developed as an activity within larger multi-service programmes (e.g., a community development project, literacy classes, in conjunction with a centre-based early childhood programme).

A short-term intervention created specifically to be used in parent groups is the Better Parenting Programme (BPP) developed by UNICEF. The programme consists of a set of video tapes and accompanying materials that are designed to present basic child development information (from birth to school entry). In adapting the materials to a given context, the 2nd half of each video is completed with examples from the local culture. BPP has been used extensively in Middle East and North Africa countries as well as in Central Europe.

A longer-term approach to parent groups has been taken in Indonesia. *The Bina Keluarga Balita (BKB)* project began in 1982. Initiated by the Ministry for the Role of Women, the major objective of BKB was to create a low-cost model that delivers child development information to mothers to enhance their capacity to support the child's development. The main target of the BKB programme is all mothers from low-income groups in suburban or rural areas who have children below the age of six. BKB groups are formed at the village level and implemented by trained volunteers (*kader*). Kader hold monthly sessions with mothers who come together in groups, based on the age of the child (birth-one, one-two, two-three years of age, etc.). During the sessions mothers learn about child development and how to use simple educational toys, language, songs, games, and storytelling in their interaction with the child. Mothers can be involved in the programme from the time of the birth of their child until the child enters a pre-school or primary school.

b. Distance parenting programmes - Media

In addition to home visiting and parenting groups, media, particularly radio, can be a powerful tool in raising awareness about the importance of parenting within the broader community. All forms of media are used. Examples include publishing magazines, books, articles, pamphlets and/or the production of television and radio programmes directed toward parents and/or to those who work with parents.

One effective strategy is to combine the use of media with parent groups. The *Programa de Padres y Hijos* (PPH) was begun in 1979 by the Centro de Investigaciones y Desarrollo de la Educacion (CIDE) in Chile. The target population is poor communities, with the immediate goal to provide parents (fathers and mothers) with information on how they can support the development of young children. The ultimate goal, however, is to support the personal growth of the adults and the overall development of the community. In order to reach these communities most effectively the programme combines distance education with a system of local groups facilitated by trained promoters. The weekly meetings are timed to coincide with a radio broadcast that uses radio dramas and other devices to pose a problem and to stimulate conversation. The discussions, which are led by a local "promoter" chosen by the community, lead to suggestions and plans for community action in the various areas, and parents then talk about activities they can do during the week.

c. programme intensity

Another dimension of delivery has to do with programme intensity. One definition of intensity is provided by Dahinten and Willms (1999), quoting Wasik & Karweit (1994), states: 'Intensity is a descriptor that is sometimes used to convey the complexity of the programme in terms of resources required, duration, frequency and total number of contacts, as well as the level of staffing and staff qualifications'. Unfortunately, what this means is that the term 'intensity' masks the various dimensions of parenting programmes, making it difficult to compare parenting programmes in relation to their intensity. As will be seen in the discussion of evaluations below, many of these dimensions make a difference in programme outcomes. For example, the frequency (how often home visits are offered) and duration (in terms of each contact and for how long) of home visits affect outcomes, but this level of detail in terms of intensity is seldom provided in descriptions of programme services.

3. Service providers

Those who work within parenting programmes directly with caregivers include both professionals and paraprofessionals with a variety of backgrounds. In considering who will work in the parenting programme it is important to take into consideration the nature of the task, the pay and conditions of work, and the nature of the supervision that the project intends to provide. In a review of parenting programmes in the UK, researchers identified '21 main categories of workers from education, health and social services departments, voluntary organizations, academic institutions and churches and other faith groups'. The majority of those facilitating parenting groups were educational psychologists and health professionals, social workers and teachers. They also noted that some programmes involve parents as leaders (Social Policy Research 91, 1996). This is a common practice in Majority World countries.

While there are exceptions, many of the home visiting programmes that are linked with health services have chosen to have nurses or other health professionals providing home visits and/or facilitating parent groups. Programmes operated by NGOs are more likely to rely on people from the community (paraprofessionals) being trained to work with their peers.

There are pros and cons to each option. One variable has to do with whether or not the person will be trusted. For example, the use of paraprofessionals may reduce barriers to participation if the person is seen as coming from the community, rather than being an outsider. In favour of professionals is their education and status which may make it easier for some parents to trust the information they provide.

Another consideration is the cost of employing professionals versus paraprofessionals. Professionals are provided with much higher salaries than paraprofessionals, and they are generally hired at a rate commensurate with their experience. On the other hand, many paraprofessionals receive little or no pay. While this is not obviously costly to the programme in the short-term, in the long-term it can become costly as there tends to be

high turnover as paraprofessionals burn out or seek other jobs. This means the programme needs to recruit and train new staff on a fairly regular basis. This is costly.

Another variable has to do with the kinds of knowledge that professionals and paraprofessionals have – before and after training. In many instances, professionals bring a core of basic information to the task and may require little additional content training. It is important to note, however, that professionals may require more training if they have little respect for what parents know. Paraprofessionals, on the other hand, may require a great deal of content training in order to have a basic understanding of the subject matter. However, they may require much less training in terms of how to work in partnership with parents.

The degree to which both professionals and paraprofessionals bring appropriate information to and participatory approaches in their work with the family depends very much on the kind of training and supervision that the programme provides for them.

4. Training and on-going support

The people who have been selected as the “best” when the project begins will only continue to be the best if they have adequate and on-going training and supportive supervision.

‘The success of the programme is highly dependent on the preparation and supervision of staff at all levels.’ (Grantham-McGregor (et al., N.D.) This cannot be emphasized enough. Research and experience tell us that training is perhaps the most important input in implementing and sustaining high-quality programmes. While the selection of appropriate people to staff the project is one of the keys to a successful enterprise, a second key is the kind of training and support that these people receive once they are part of the effort.

The extent and kind of training that will be required will depend on the content to be conveyed, the basic education of the person working with parents, and the expectations around what it is the person will be delivering. Regardless of the model being chosen, however, training must be a priority. It needs to be carefully thought through, systematic and continuous, with supervision over time that supports the growth of the service providers, whether they are professionals or paraprofessionals.

5. Evaluation

The last, and frequently least thought through, dimension of parenting programmes is how the programme will be documented and evaluated. While there are parenting programmes in nearly every country, there are few that have been accompanied by solid research and evaluation processes. The programmes that are likely to have the best evaluations are found in resource-rich countries, while those in the Majority World are much less likely to have been evaluated in either the short- or long- term. In addition, as has been noted, parenting programmes vary in terms of the population to be served (including the age of children being served), as well as their intensity and method of delivery, which complicates assessment and comparison of outcomes. In the section that follows there is a discussion of evaluations of parenting programmes that have medium- to long-term outcomes. .

III Evaluations of Parenting Programmes

Previous reviewers of parenting programmes (Myers and Hertenberg, 1987; Dahinten & Willms 1999; Carter 1996; Wasik & Karweit, 1994) had access to short-term evaluations. As a result, for the most part these reviewers concluded that little can be said about the impact of parenting programmes, and while there are still issues to be addressed as mentioned in previous reviews (lack of adequate funding, lack of shared definitions, inadequate methodology, the lack of evaluation specialists in the field of parenting programmes, etc.) *the body of literature available by 2006 would suggest that parenting programmes can and do have a positive impact – on the child, on the parent and frequently on the service provider.*

The discussion of evaluations that follows describes what has been done to evaluate parenting programmes and the outcomes of those evaluations. The evaluation results are organized by sector, the age of the child when the programme begins, the way services are delivered, and the kinds of follow-up evaluations that have been conducted and their results. It is important to note that many of the programmes reviewed were pilot projects and had a relatively small sample. Where sample size is known it is mentioned.

A. Parent Programmes developed by the Health Sector

The great majority of parenting programmes that have randomized controlled trials as part of the design have been created by the health sector. They are found primarily in resource-rich countries, with the notable exception being the work of Grantham-McGregor and others in Jamaica. In general, health professionals provide direct services to the families in these programmes.

1. Programmes that begin prenatally

There is a set of parenting programmes that have focused on enhancing birth outcomes and providing support during the child's early years. Most of these programmes focus on

first time parents and parents from at risk populations. These programmes begin working with women during the prenatal period to better their nutritional and health practices, and then continue for 2-3 years to facilitate the mother's personal growth and support the mother/child interaction to enhance child outcomes.

One of the most thoroughly researched parent infant programmes is what is now known as the Nurse-Family Partnership (NFP) programme in the USA. The NFP program began in 1977 at three sites and involved about 2000 families that continue to be followed. Experimental and control groups were a part of the study. In terms of programme delivery, mothers were enrolled during the third trimester of pregnancy. Visits took place bi-weekly from the time of enrolment until the toddler was two years of age. During the 6 weeks immediately after the birth the family was visited weekly and for the last few months visits were made monthly. The focus of the visits was on personal health, maternal role development, environmental health, maternal life-course development, and family and friend support.

The longitudinal follow-ups are looking at programme effects on maternal economic self-sufficiency, substance abuse, and children's adaptive functioning, including their mental health, criminal behaviour, and productive life-course as the children reach adolescence and young adulthood. For example, results indicated that for the children of participating mothers, there were 56% fewer arrests and 81% fewer convictions than among control group children (<http://www.nursefamilypartnership.org/index.cfm?fuseaction=home>).

2. Programmes that begin at birth

Another set of programmes picks up the family if there is a low birth weight baby. For example, in the USA, the Infant Health and Development Programme (IHDP), a three year programmes begun in 1985, was a large randomized, 8-site demonstration project that provided early child development and family support services for approximately 1,000 low-birthweight and premature infants and their families who varied widely in socioeconomic status. The goal of IHDP was to reduce the developmental and health problems of low birth weight premature infants. The services included home visits by

professionals during the first year, enrolment at a child development centre five days a week at the age of two, and parent groups that began when the child was 12 months old that met every two months (Child Trends, 2003).

The most recent follow-up was conducted in 2000, and according to a review in Child Trends (2003),

Significant positive outcomes were found for children and parents. The intervention was associated with substantially higher levels of cognitive and socio- emotional development at 24 and 36 months, with greater effects found for higher birth weight infants and children of less educated mothers. The heavier infants were also more likely than the lower birth weight infants to show sustained cognitive effects up to 8 years of age.

However, Dahinten and Willms (1999) report that McCarton (et al. 1997) concluded that the differences between the groups faded out after the age of eight.

The Dahinten and Willms (1999) review included a report on the Project CARE in the USA, which was also a randomized controlled trial that had two models – home visiting, and home visiting plus a centre-based daycare programme – and a non-intervention control group. The programme worked with at-risk families of biologically healthy infants for 5 years - beginning within 3 months of birth and continuing until the child entered school. As summarized by Dahinten and Willms (1999) ‘The results of various child outcome measures (e.g. the Bayley Scales of Infant Development, Stanford-Binet Intelligence Tests, McCarthy Scales of Children’s Abilities), administered between 6 and 54 months, demonstrated significant cognitive treatment effects for the daycare plus home visit group, but not for those receiving only the home visits.’ A cautionary note is provided by Dahinten and Willms (1999) who suggest that

Although the results of Project CARE imply that parent education alone may not be an effective intervention, the findings may be explained in part by the intensity of

the home visits... Families received an average of 2.5 visits per month during the first 3 years, and 1.4 visits per month during the fourth and fifth years. This contrasts with the weekly visitation schedule recommended by Powell and Grantham-McGregor (as cited by Wasik et al.) in response to their study on the effects of weekly, biweekly and monthly visits among poor urban children in Jamaica.'

In the Jamaica programme home visiting/counselling was the only intervention and highly effective. Thus the important variable here may not be that home visiting alone was provided, but how often visits are provided.

3. Programmes integrated into basic health care services

An evaluation of the Integrated Nutrition and Community Development Project, in Thailand described above was conducted to assess the impact of the project on children's nutrition. As a result of the project, fewer children suffered PEM. On the basis of interviews with mothers of children under the age of two, and of observations in the home, evaluators of the project concluded that changes in the mothers' beliefs and behaviours were critical variables in improving children's nutritional status (Kotchabhakdi 1988).

Those involved in evaluating the program also concluded that videos are a powerful technique when working with illiterate adults. The visual images provided through the videos stimulated discussion and presented mothers with models of behaviour which they could imitate. When observers went to the villages they noted more adult-child interaction, more open cradles, and more colostrums being given. The results suggest that a focus on the psycho-social components of feeding (i.e., care) can make a significant difference in children's nutritional status. (Kotchabhakdi 1988)

The program continued. From 1990-1996 the program—known as the Integrated Family-Based Early Childhood Development Program—was implemented in sixteen provinces. In 1996 it was scaled-up and became operational in seventy-five rural provinces. Now it is called the Family Development Program. A note in the 1997 evaluation of the project is important in terms of what happens frequently when projects are ‘scaled-up’.

“While the Integrated Family-Based Early Childhood Program was a successful model of collaboration for families and children, the large-scale Family Development Program has so far been less effective...the quality of the scaled-up program seems to have decreased. However, the program demonstrates a model of cross-sector collaboration and integrated programming on which all sectors can build.” (Herscovitch 1997, 5)

Another programme operated by the national health system is the Community Mothers’ Programme (CMP) in Ireland, derived from the HIPPY model described below. In 1989, 232 first-time mothers were randomly selected to be in either a group receiving the CMP or a control group without the CMP, and they were all followed up a year later when their babies were one year old (Molloy 2002).

The CMP provides support to new mothers of infants less than 1 year of age. The premise in this programme is that mothers’ own needs must be addressed in order for the child’s needs to be met. Originally the home visitors were health professionals but over time community mothers delivered the service.

The first evaluation was done the year following the intervention. Molloy (2002) notes:

The results were encouraging and showed favourable outcomes for the Programme families – when compared with the control families – in areas such as maternal self-esteem, maternal and child nutrition, developmental stimulation, maternal morale and well-being, and immunisation. These are, in themselves, good outcomes at the end of a one-year programme.

According to a follow-up seven years after the first group of mothers completed the programme, (children were age eight), the early findings were replicated, leading Molloy (2002) to conclude ‘that the CMP has a beneficial impact on parenting skills and maternal self-esteem that is sustained over time and which is carried through to subsequent children.’ The programme now operates with at risk families in a variety of communities in Ireland, but no evaluation has been conducted to see if the results obtained in the pilot project are replicated as the project scales up.

Another programme based in the health care system that uses mothers from the community (peers) as supports to other mothers is based in Holland. Known as the *Moeders Informeren Moeders* Project (Mothers Inform Mothers - MIM), this programme is primarily based on the Irish CMP and targets mothers from socially vulnerable environments, who are not readily reached by regular healthcare services. The programme starts early, ideally just before confinement. All first time mothers living in the participating areas are offered the programme but special attention is given to socially disadvantaged groups, members of immigrant communities and children in need. The programme is now being offered through the health system in eight sites in The Netherlands. (de Graaf, et al., 2000).

In both the CMP and MIM programmes, the major evaluation methodology was interviews with women who participated in the programme and those who provided the services.

B. Education or Social Sector Programmes

1. Programmes that begin within the first year of a child’s life

In Honduras, the Early Stimulation Programme, a model quite similar to the HIPPY approach, was developed in 1995 by the Christian Children’s Fund (CCF). The

programme combines home visits for children in the 0-4 age group, with children transitioning into a CCF preschool for ages 4-6.

In 2002 participants in the home visiting programme were followed-up. The follow-up was conducted on 10 former participants (the CCF group) when they were nine or 10 years old and a matched group (the comparison group) from another village where no such early childhood programme existed. While the standard health and school performance indicators were assessed, of importance to the programme were social and relationship variables as well (emotional and social development of the children in the family, the behaviour of the child outside of the family and changes in children's psychosocial relationships).

Overall, there were significant differences between the intervention and control groups with regard to living conditions, health, education and the well-being of children and their families. The researchers note that for them the most important difference between the two groups was the contrast in the 'internalization of the children's values and their outlook on the future.... Above all, there was a clear strengthening of their affective bonds to family members and other people within their community' (Figueroa et al., 2004).

The *Padres e Hijos* Program in Chile that used a parent group format was evaluated early on in its history to determine its effects on the child, the parents, and the community (Filp, et al. 1977). Children (program and non-program – sample size unknown) were rated by teachers in terms of their readiness for school. Children whose parents were in the program were rated higher. On the WISP (a Chilean version of the Weschler scale), over a four-month period of time, the PPH children improved 6.2 points compared to an increase of 3.4 points by the non-PPH children. (Myers and Hertenberg 1987, 84) Changes in the adults were evidenced by different attitudes and actions in terms of the way they talked about the project, reached agreements, and acted on decisions. "The basic change identified was from apathy to participation in constructive activities as a sense of self-worth was strengthened." (Myers and Hertenberg 1987, 84)

2. Programmes that begin when the child is of preschool age

a. *Targeted programmes*

These programmes can consist of home visits or parent education/support groups, or they can offer a combination of both. One set of programmes that combine both began with the Home Instruction Programme for Preschool Youngsters (HIPPY), a school-readiness parenting programme that was developed in Israel in 1969. HIPPY has since been adapted into the Turkey Early Enrichment Programme (Mother-Child Education Programme), the Community Mothers Programme (CMP) in Ireland, the Mothers Inform Mothers (MIM) Programme in The Netherlands and Parents as Teachers (PAT) in the USA. All these programmes have a structured curriculum for pre-school-aged children that mothers are expected to use with the child. The home visitor demonstrates how to work with the child and the mother uses this process with the child between visits. Interspersed with the home visits are parent group meetings. The spacing of the home visits and group meetings differ across the various adaptations of the model.

Dahinten & Willms (1999) note only one evaluation of the HIPPY model, which was a 3-year longitudinal study of the programme in the USA, that found positive effects on intervention children for social, emotional, and cognitive development, as well as better school achievement and higher retention rates for children who participated. Children whose parents had participated in HIPPY were found to be ‘significantly better adapted’ than children of mothers not in the programme (Carter, 1996, p. 77 as cited in Dahinten & Willms 1999).

A programme that took the HIPPY model and adapted it in Turkey has followed participants for 18 years. The Mother-Child Education Programme (MOCEP), which evolved into the Turkish Early Enrichment Project (TEEP), consisted of an intervention carried out in 1983-1985 that was assessed at the end of the programme in 1986, with follow-up studies in 1992 and 2004. Findings from 132 of the original 255 participants in the study, across the evaluations the findings, indicate that ‘profound changes in the

mothers and the home environment of the mother training group' over the years has had a significant impact on the children across their schooling and into adulthood (Kağıtçıbaşı et al. in press).

In the follow-up in 1992 one of the most evident differences had to do with school retention and achievement. For example, 86% of the children in the Mother Trained group, but only 67% of the non trained group were still in school. And on the majority of school subjects for the adolescents, those in the Mother Trained group did significantly better (Kağıtçıbaşı, et al. 2001).

b. Universally available programmes

Programmes that are open to enrolment from anyone in the community are much more difficult to evaluate. When programmes are offered universally, those offering the programme are not likely to be able to set up an experimental design to evaluate the outcomes. This is the case for the Parents as Teachers (PAT) programme in the USA. It was established in 1981 and has since been adopted in Canada, Australia, New Zealand, England, Malaysia, and the West Indies.

PAT is similar to HIPPIY in content and delivery, but it is universal in coverage, rather than being a targeted programme, aimed at all parents of children from birth to age 5. PAT is staffed by certified parent educators who have a background in teaching or early childhood development. The scheduling of home visits and parent groups is flexible, depending on the needs and interests of the population being served. In addition, some programmes have drop-in centres and children's play times available to complement other activities. Evaluations of PAT have been conducted in a variety of contexts and with different comparison groups. Looking across these evaluations Carter (1996, as cited in Dahinten and Willms 1999) 'suggests that [PAT's] effectiveness with low-income families remains uncertain'. It is unclear why this might be true.

3. Programmes of Relatively Short Duration

As noted, some narrowly focused programmes that are of short duration include an evaluation component, although these programmes tend to be limited by small sample size and/or lack of long-term data. Shrimpton and Lucas (2005) provide two examples of focused short-intervention nutrition programmes.

In a study in Mexico 'mothers in a control group exclusively breastfed their three-month-old infants at the rate of 12% (no sample size was given). The rate increased to 50% if mothers received three home visits by lay counsellors, and 67% if they received six home visits (Morrow et al. 1999, as quoted in Shrimpton and Lucas, 2005). In a study in Brazil, (Santos et al. 2001), it was found that counselling mothers with the nutrition guidelines promoted by WHO and UNICEF through the Integrated Management of Childhood Illness (IMCI) strategy improved feeding practices and growth in a clinic-based study (no sample size provided). Doctors counselled mothers in a single face-to-face session with their sick children. Observations of feeding at home 8, 45, and 180 days after the consultation found improvements in feeding practices, the intake of food and weight gain of children age 12-18 months (as reviewed by Shrimpton and Lucas, 2005).

The impact of such focused nutrition interventions can be seen at the end of the programme, and because of related research the long-term outcomes for children can be extrapolated. This is not true when psycho-social outcomes are sought. Dahinten and Willms (1999, citing Wasik & Karweit, 1994), describe two programmes (Mother-Child Home Programme and the Family Oriented Home Visiting Program) where home visits occurred over 7 and 9 months respectively. The focus of these programmes was on verbal interaction, a difficult outcome to measure both short- and long-term. 'Both programs showed immediate effects for the intervention children, but the effects were either not sustained beyond the year, or there were inadequate data to make a further assessment.' (Dahinten & Willms, 1999) The age of the children was not included in the description of the study, nor was there a discussion of the methodology.

Another relatively short-term approach to educating parents (consisting of 8 parent group meetings) was taken by UNICEF who developed a curriculum to be used with parent

groups - the Better Parenting Programmes (BPP). With the help of Jordanian consultants the original materials were adapted culturally as necessary, translated into Arabic, and produced as four video presentations, four accompanying parent booklets, and three Facilitator guides to the use of these materials. The Jordanian adaptation of the programme, begun as a pilot programme in 1996, was evaluated in 2000 (Brown, 2000). In all, the Pilot phases trained 44 facilitators, and 900 women attended the parenting series of sessions.

As described by Brown (2000), in the first phase, programme participants (all women, mostly mothers) were given pretest questionnaires on their child-rearing knowledge and practices before attending eight sessions in which a portion of a video film was shown, printed materials were distributed, and the film and materials were discussed by the women. Post-test questionnaires probed the extent to which these women's knowledge had increased, and whether behaviour in relation to their children had changed. Brown (2000) noted that in a summary report of an evaluation conducted after Phase 1,

for the 112 mothers who attended every one of the eight sessions (out of the 214 who attended some), the findings demonstrated that the program had a statistically significant effect on creating differences in the performance of mothers, as measured against the pre and post-participation evaluation tools. Improvement was observed in the level of the mothers' knowledge in the areas of child growth and development....The program also contributed towards improving the mothers' patterns of parenting. No differences were found in the performance of literate or illiterate mothers.

At the end of the Pilot project, approximately 900 women had participated in BP courses. The totals for 1999 show a total of over 6000 participants, with over 8% of these being men (Brown 2000). In summarizing what she has found, Brown (2000) states

The consultant takes as a "given" that the product being delivered to parents has been widely valued, and is in increasing demand. However, the kind of impact

assessment that is now called for... is one which measures the ultimate objective of the programme—the impact on the outcomes for the children. This is a much more complicated type of impact to measure. To do it quantitatively in a truly scientific way is a major and costly undertaking. A number of less costly approaches could be considered to obtain substantive measures of impact on child outcomes which could guide further programme development (Brown 2000, 19).

4. Sleeper and Fading Effects

One possibility when no results are found at the end of a programme is that there might be a ‘sleeper’ effect, with differences showing up over time. Dahinten and Willms (1999) describe the Mother-Infant Transaction Program, where the effects of a short (3-month) parent-focused intervention aimed at low birth weight infants were not evident until the children reached 36 months of age. The positive effects for the intervention groups were then sustained to age 7 (Achenbach, Phares, Howell, Rauh, & Nurcombe, 1990; Rauh, Achenbach, Nurcombe, Howell, & Teti, 1988 as cited in Dahinten and Willms 1999).

The hypothesized sleeper effect might also explain the findings of a randomized controlled trial of prenatal and infancy home visitation by public health nurses in Tennessee, which failed to find any programme effects on the children’s mental development or behaviour at 2 years of age, although there were physical health benefits to both the mother and child (Kitzman et al., 1997 as cited in Dahinten and Willms 1999). It is relatively easy to measure a child’s health at age two. However, the impact of a programme on children’s mental development is hard to measure at age 2. Despite what appear to be successful adaptations of the Bayley Scale and some other developmental assessment instruments in the Majority World, there is considerable disagreement on the extent to which tests of cognitive ability can be applied cross-culturally (Evans et al. 2000). As Greenfield (1997) notes,

The most valid research instruments are derived from cultural meanings in a group where the instruments are to be applied. When a given instrument is used beyond the culture in which it was developed, it is necessary to research the meaning or meanings that participants in the new culture attach to the instrument and to its procedure. (1122)

The opposite of sleeper effects is when there are significant differences in outcomes at the end of a programme, or at different points in a follow-up, that appear to fade over time. For example, in the IHDP project described above significant differences were found at the end of the project. However, these differences appear to have faded out by age 8 when it was found that there were no overall significant differences between the intervention and follow-up groups (McCarton et al 1997 as cited in Dahinten and Willms 1999).

In the issue of sleeper effects it may be that the input, in terms of mother/child interaction for example, took time to have an effect. In the case of differences fading, there may also be a sleeper effect if the groups are followed over time. The question in both these instances is what is being measured and how? For example, it may be that different variables need to be measured over time. The classic case is the Perry Preschool Study where differences between the experimental and control groups at age 8 seemed to have disappeared. However, when social variables (school completion, delinquency rates, teen-age pregnancy rates, amount of time on welfare, rates of employment, annual income etc., were measured in follow-up studies (the latest at age 40), the differences between the two groups have been consistently significant on socio-economic indicators (Schweinhart, et al. 2005).

Another set of studies that contribute to understanding long-term outcomes of parenting programmes is the research that continues to be conducted on the Mother Child Education Programme in Turkey, which demonstrates that results at a given point in time are not stable. In the 1996 follow-up study, educational day care appears to have stronger effects than Mother Training. However, in the second follow up (2004), children, now

young adults, of the Mother Training group was again compared with children from the educational preschool, the custodial care programme, and the children where there was no intervention. At this follow-up an interesting finding was that the children who had the educational preschool did as well as the Mother Training group: both did better than the other groups. This suggested to the researchers ‘that effects of early experience are not fixed at some point but rather are dynamic, emerging at different points in development and experience.’ (Kağıtçıbaşı et al. 2005) They went on to conclude that

High-quality early childhood educational interventions have positive effects on the overall development of the child which carry over to adult life, affecting life chances through higher levels of educational attainment, delayed entry into the work force, and higher-status occupations. Both mother training and educational preschool day care were associated with more positive outcomes with regard to academic success and cognitive skills, socioeconomic success, and indices of social and economic integration into the modern urban world Kağıtçıbaşı et al. 2005.

Given these caveats, it is unclear what any parenting programme might yield over time if we knew how to assess the right variables in appropriate ways. However, most education and social service programmes lack the resources to conduct longitudinal studies that would give insight into the long-term impact of parenting programmes – for children, parents, the family and society at large.

5. Who benefits most?

A number of studies have suggested that parenting programmes are likely to have an impact on at-risk families, but that it is less likely to see an impact on white middle-class families. For example, a 3-year study of parent provision open to all families, failed to find significant cognitive outcomes for the children of predominantly middle-class families (Owen and Mulvihill 1994, as cited in Dahinten & Willms 1999). This is not surprising. Many middle-class families seek out and have access to information on

parenting and children's development. This information is part of their wider culture. This is not so true for at risk families. Thus when they have an opportunity to access the information they benefit from what is being provided.

In summary, the research and evaluation literature on parenting programmes is not very illuminating in terms of being able to make cross-programme comparisons. Nonetheless, a judicious review of both programme and corollary child development outcomes suggests that parenting programmes can make a significant difference for participating children and their families, and, over the long term, they can make a difference for societies.

IV Discussion

In their review of parenting programmes, Dahinten and Willms (1999) make a distinction between what they refer to as one-generation and two-generation parenting programmes. In the former the concern/focus of the programme is on adult OR child outcomes, whereas in the latter there is a focus on both parent/caregiver and child outcomes. In reviewing evaluations, however, it is evident that even though a programme may technically be focussed on child outcomes, in reality there are likely to be outcomes for the parent, and vice versa, and, interestingly enough, when it is explored, it is evident that there are also positive outcomes for the person providing the service. What follows is a brief summary of the impact of parenting programmes on the children, the parents involved in the programme, and the programme provider.

1. *Impacts on children*

In the longitudinal studies reviewed there are gains for children at the end of the programme on standardized child development measures (health, nutrition and a range of cognition and language tests). Also, when cohorts have been followed over time, the impact is often seen in improved school retention and achievement. In addition, when groups have been followed into adulthood, economic and social indicators have been used to demonstrate the lasting impact of various parenting programmes. Attitudes about oneself are seen as important in some studies, with children who participated in the programme being defined as self-confident and motivated to do well. In addition, some programmes have attempted to measure values – defined as the child's orientation to and respect for family and community. When followed into adulthood, variables assessed have to do with the individual's integration into society and outlook on life – their adaptive functioning and productive life course. In Table 1 is a listing of the specific variables and the studies in which they were assessed positively for the intervention groups.

2. *Impacts on parents*

All the parenting programmes reviewed found positive outcomes for parents (all mothers in this case), if the researchers chose to assess parent outcomes. It is important to note, however, that parent impact data have been gathered largely through self-report and/or interviews with those who worked with the parents. No other techniques have been used to assess impact. (As Grantham-McGregor notes, ‘further research on the use of parental reports and other approaches, including brief observations, is needed.’)

The impact for parents (mothers) has to do with changes in how she feels about herself; this leads to changes in behaviour. Words such as increased self-confidence, self-esteem are sprinkled throughout the results. This leads to mothers being more independent and better able to make decisions. With greater self-esteem, mothers become more capable of being responsive to her children. Through the programmes the mother comes to understand how important she is in the child’s life. She is more aware of the child’s development and her role in supporting that development and the mother’s interaction with the child changes. She engages with the child through reading, talking and playing with the child, and providing opportunities for learning and she is more supportive of children’s participation in school. Overall she is warmer with and closer to the child – a stronger bond is created.

Changes brought about by the mother’s feelings of greater self-worth spill over into her family life and into her willingness and openness to share her experiences with others (this motivates some to become home visitors) and to become more involved in a range of programmes within the community. Some become social activists; their new knowledge gives them confidence to speak out for children in their communities.

Molloy (2002) sums up the changes in mothers as empowerment. ‘Empowerment is a process by which individuals, groups and communities become able to take control of their lives and achieve their own goals, thereby being able to work towards maximizing the quality of their lives’ (Molloy 2002). While the CMP and MIM programmes

explicitly speak to empowering women, empowerment is the outcome of many of the programmes.

3. *Impacts on service providers*

Few parenting programmes have made an attempt to assess the impact of the programme on those who provide the service. But when that has been explored, there impact on the providers is evident. Some would even suggest they gain the most of anyone (Jamaica). They gain respect and status within the community. In Honduras ‘they carry the book’ (de Figueroa et al. 2004). They become community leaders and they have expanded employment options.

V. Conclusions

Overall, the results of the research and evaluations summarized above, and other literature, suggest that beginning intervention programmes during pregnancy rather than later may increase the effectiveness of the programme and that such interventions may be most effective with young or first time mothers, and/or mothers at risk due to their circumstances. In addition, if families are visited often (once a week over a year or more there are better outcomes than if home visits are less frequent (bi-weekly or once a month) and are of short duration (i.e., less than a year). In addition, while short-term outcomes can be measured in relation to health and nutrition indicators, the positive impact on children’s cognitive, language and socio-emotional development is harder to measure post programme, but may become evident if children are followed long-term. Nonetheless there are some confounding factors that continue to inhibit our full understanding of the impact of parenting programmes include:

1. *The wide variation in models.* As can be seen from the description of the programmes reviewed, they vary in terms of populations served, ages covered in the programme, the combination of programming options (home visiting and/or parenting groups) that have been included, the characteristics of those providing

services, the kind of training they receive, and the variables that are considered as important to assess – at the end of the programme and over time. Also when a parenting programme is part of a larger set of activities (within the health sector or a development programme) it is hard to identify specific factors that contribute to outcomes.

2. *The lack of appropriate, valid and reliable instrumentation.* Many of the programmes rely on instruments developed in North America to assess impact. In Majority World countries people adapt some of these instruments to fit their context and/or create their own instruments. The result is that outcomes for children, in particular, cannot be compared across cultures. But this is not necessarily the most important function of evaluations. What is important is that people can reliably assess what is happening for children within their own culture. The data generated can have an impact on national policy and services. For example, de Graff (et al 2000) in The Netherlands have used evaluation data to advocate for and make changes in the National Health Service delivery system.
3. *The need for process measures.* An important function of evaluations is to monitor the implementation process to assess strengths and weakness and then make changes in the programme. Several of the evaluations noted the ways in which this has happened. In Ireland, staff changed the length of time that families are involved in the programme from one year to two ‘in order to enhance the effects even further’ (Molloy 2002).
4. *More information on costs.* Almost none of the studies reviewed looked at the costs of the programme. While the one-to-one model within home visiting programmes is generally seen as costly, the outcomes related to this model have not been linked to costs to know the cost-effectiveness of this type of intervention. For the most part there has been no systematic study of the costs of parent groups, let alone a linking of costs to outcomes.
5. *An assessment of parenting programmes for alternative caregivers.* As noted early on in the article, in today’s world parenting is provided by a wide range of people within the extended family, and sometimes beyond. The programmes being created for a broader range of caregivers are relatively new (as in the case

of those working AIDS orphans, for example) and have not yet been assessed, but results from evaluations of these efforts will bring an important new literature to bear on understanding the impact of parenting programmes.

The fact that there is a lack of unequivocal research and evaluation results for parenting programmes does not mean that investment in them should cease. In fact, investment in such programmes should be increased. The results of long-term evaluations of those programmes that have appropriate data suggest that parenting programmes can and do have a lasting impact. The critical importance of the early years has been well-established as has the importance of quality parenting. The fact that the parenting process has been disrupted for a major segment of the world's population makes it imperative that even more attention be given to creating programmes that provide information and support to all those who parent, particularly those who are parenting children during their early years.

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